ELIGIBILITY REVIEW FOR FAMILY AND CHILDREN'S MEDICAL BENEFITS

Washington State Department of Social & Health Services

HealthyKidsNow

This eligibility review is a statement of facts about the people who want medical benefits. You need to answer all of the questions before we will know if we can continue your medical benefits.

☐ **Please send me information about cash and food assistance programs.**

Please print.

1. First Name	Middle Initial	Last Name		
2. Address Where You Live — Street		City	State	Zip Code
3. Mailing Address (if different) — Street		City	State	Zip Code

4. Telephone Numbers

Home ( ) _____

Work ( ) _____

	Yes	No
5. Do you have trouble speaking, reading or writing English?	☐	☐
Do you need materials sent to you in another language?	☐	☐
Do you need an interpreter? (If yes, we will get an interpreter.)	☐	☐

What language do you speak? _____

6. A person in my household is pregnant. Yes ☐ No ☐ If yes, who? _____

Expected date of delivery _____

General Information

7. A person in my household is disabled. Yes ☐ No ☐ If yes, who?

8. List family members living in the same household: (this information will not be shared with INS)

Name (first, middle, last)	Relation to you	Birth Date (mm/dd/yy)	U.S. citizen Yes	U.S. citizen No	If not a U.S. citizen, was person given a document showing status? (attach document) Yes	If not a U.S. citizen, was person given a document showing status? (attach document) No	List date this person arrived in U.S. (mm/dd/yy)	Does this person have a sponsor? Yes	Does this person have a sponsor? No	Social Security Number (optional if person does not want benefits)	Sex M/F
A. Parent/Guardian or Self			☐	☐	☐	☐		☐	☐		
B. Parent/Guardian/Other			☐	☐	☐	☐		☐	☐		
C. List All Other Persons:			☐	☐	☐	☐		☐	☐		
D.			☐	☐	☐	☐		☐	☐		
E.			☐	☐	☐	☐		☐	☐		
F.			☐	☐	☐	☐		☐	☐		
G.			☐	☐	☐	☐		☐	☐		
H.			☐	☐	☐	☐		☐	☐		
I.			☐	☐	☐	☐		☐	☐		

Expenses

9. Do you pay someone to take care of your children or to take care of a dependent adult while you work? Yes ☐ No ☐

If yes, how much per month? $ _____

10. Do you pay court ordered child support for a child who does not live in your home? Yes ☐ No ☐

If yes, how much per month? $ _____

Income

11. Your income from employment

☐ Check if you are self-employed

Employer Name _____

Telephone Number ( ) _____

Amount you earn each pay period before taxes: $ _____

☐ Weekly ☐ Every two weeks ☐ Twice a month

☐ Monthly Hours worked each week _____

12. Income from employment of spouse or family member living in the home.

Name of other person with income _____

☐ Check if this person is self-employed

Employer Name _____

Telephone Number ( ) _____

Amount earned each pay period before taxes: $ _____

☐ Weekly ☐ Every two weeks ☐ Twice a month

☐ Monthly Hours worked each week _____

Other Income Received by Anyone in Your Home	Amount	How Often is This Income Received?	Which Family Member Earns This Income?
13. Child Support	$		
14. Alimony	$		
15. Social Security Payment	$		
16. Unemployment Benefits	$		
17. Interest from Bank Accounts	$		
18. Veterans Benefits	$		
19. Labor and Industries	$		
20. Military Allotments	$		
21. Rental Income	$		
22. Other (please explain)	$		

Note: If you need more space for jobs or more income, please add a separate sheet.

Health Insurance Information

	Yes	No
23. Does anyone wanting continued medical benefits have private health insurance?	☐	☐
Have you had job-related health insurance for *your children* in the last 4 months?	☐	☐
If **yes**, does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services?	☐	☐
If **yes**, did the premium cost less than $50 per month for dependents?	☐	☐

If you checked **yes** for any of these questions, please complete the insurance questions below.

Insurance Company or Employer	Policy Number	Policy Holder's Name	Policy Holder's SSN

Voluntary Information

We ask you to voluntarily tell us your race or ethnic background. This information will not be used in considering your eligibility for benefits.

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____

Discrimination is prohibited in all programs and activities administered by the Department of Social and Health Services. No one shall be excluded from these programs and activities on the basis of race, color, creed, political beliefs, national origin, religion, age, sex or disability.

Read Carefully Before You Sign

I UNDERSTAND THAT:

- I must report immediately to the Department of Social and Health Services (DSHS), in writing or by telephone, any changes in my situation. Late reporting may cause incorrect benefits.
- My situation is subject to verification by DSHS or other state or federal agencies.
- I must provide proof that I am eligible for help. DSHS may help me obtain the proof or contact other persons or agencies for it.
- By asking for and receiving medical care benefits, I assign to the State of Washington all rights to any medical support, and to any third party payments for medical care.
- DSHS may share my child's immunization history with the Department of Health's Child Profile Immunization Tracking System.
- **I understand this eligibility review is for medical benefits only. If my family needs financial or food assistance, we must apply through a DSHS Community Services Office (CSO).**

Declaration and Signature

I have read and I understand the information in this eligibility review form. I declare, under penalty of perjury, the information I have given in this review form is true, correct, and complete to the best of my knowledge.

SIGNATURE OF APPLICANT	DATE	SIGNATURE OF SPOUSE/GUARDIAN	DATE